STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525292	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Health Services	516 26th Ave Monroe, WI 53566

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, no later than 24 hours if the events that cause the suspicion do not result in serious bodily harm for 1 of 3 sampled residents reviewed (R10). R10 was found to have a injury of unknown origin (bruise) on her upper right arm on 7/7/24. This was not reported to the State Agency until 7/11/24. This is evidenced by: According to S483.12(c)(1) of the State Operations Manual; all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. The facility policy entitled, Abuse, Neglect, and Exploitation, dated 7/15/22, includes in part: IV. Identification of Abuse, Neglect, and Exploitation . B. Possible indicators of abuse include, but are not limited to: . 2. Physical marks such as bruises or patterned appearances . 3. Physical injury of a resident, of unknown source . VII. Reporting/Response A. The facility will have written procedures that include: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 3 hours after the allegation is made, if the vents that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the event that causes the allegation do not involve abuse and do not result in serious bodily injury . R10 was admitted to the facility on [DATE], with diagnosis that include, in part: Alzheimer's disease, osteoporosis, dementia, generalized anxiety disorder, and major depressive disorder. Review of R10's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/23/24 indicates R10 has no Brief Interview for Mental Status (BIMS) score due to the resident is rarely or never understood. Progress note dated 7/7/24 at 10:07 PM states: [CNA] reported to this writer that resident was in pain every time[sic] she/they repositioned her. Noted bruise on her right upper arm 3.5cm x 8.5cm. This writer lift [sic] resident's arm slowly and she flinched[sic], with facial grimacing noted. This writer notified hospice and talked to [Nurse], and that she will send someone tomorrow morning to assess her, to notify her family since its not urgent, and to update her medications; to give her some tylenol for now for pain prn (as needed). Progress note dated 7/11/24 at 8:19 AM, states: This writer heard resident's daughter [Name], in resident's room talking loudly towards staff doing cares. This writer asked her to come to SS (Social Services) office to discuss further. Daughter continued to express her frustrations to SS; Admin. also introduced himself to daughter; offered care conference with family. SS will contact APOA (Activated Power of Attorney) [Name] to schedule. The Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report was initially submitted by NHA A (Nursing Home Administrator) on 7/11/24 at 9:56 AM. The Allegation type is listed as injury of unknown source: injury was not observed and is suspicious because of the extent or location. (of note, this is over the required reporting time) The final investigation was submitted on 7/17/24 at 3:00 PM. R10's Physician Progress note, dated 7/16/24, indicates an x-ray was conducted on 7/12/24 that indicates a fracture with displacement of the humeral head with osteoporosis. The note also states, She has contractures. I suspect that during routine care (dressing/bathing), the upper arm may have been manipulated to change her clothing or provide hygiene and she developed a pathological fracture due to osteoporosis. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 1:43 PM, Surveyor interviewed NHA A. Surveyor asked NHA A what his process is for reporting and investigating injuries of unknown origin. NHA A states that if we suspect anything we suspend employees as necessary and notify family. NHA A also states he could guess what I was referring to and states that R10's family did not want anything done at first, and when they did the facility started with x-ray and labs. The Physician then ordered R10 adaptive clothing due to the discovery of a pathologic fracture. Surveyor asked NHA A how soon injuries of unknown origin should be reported to the State Agency. NHA A states as soon as we know there was an injury, NHA A also states that he did report it and DON B (Director of Nursing) also knew about it right away and when he assessed it, DON B determined that the bruise was from changing R10's clothing so it was not an injury of unknown origin. Surveyor asked NHA A when the injury was discovered. NHA A stated 7/7/24, but DON B determined that the injury was not of unknown origin as it came from changing R10's clothes. Surveyor asked NHA A when his initial report was submitted. NHA A states, 7/11/24. NHA A also states the only reason he reported this incident at all was because R10's family came in and was yelling at facility staff, alleging abuse. On 8/8/24 at 4:02 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how he was notified about R10's bruise. DON B states he was called immediately after the injury was discovered. DON B states that a CNA found the bruise and that it was small, about the size of a 50-cent coin. DON B gestured a small circle with his hand, roughly the same size as a 50-cent coin. Surveyor asked DON B if he would consider this bruise an injury of unknown origin. DON B states, I guess I would call it that. The next day when I came back in to reassess the resident the bruise was halfway down her arm. DON B gestures from the middle of his upper arm down to just below the elbow area. DON B also states that R10 has a long history of osteoporosis. Surveyor asked DON B what made the facility decide to further pursue an x-ray after the family initially denied it. DON B states because the bruise got bigger. DON B also states that he has seen multiple injuries in the past where a shoulder can be injured that can also cause these types of bruises to grow. Surveyor asked DON B when the decision was made to report this injury to the State Agency. DON B states when a family member came in screaming and alleging abuse. Surveyor asked DON B how soon abuse or injuries of unknown origins need to be reported. DON B states, immediately, especially when alleging physical harm. Of note, according to DON B, the bruise became significantly bigger on 7/8/24 and the injury was still not reported until 7/11/24, after R10's family member alleged abuse. R10's injury of unknown origin was not reported within the required timeframe.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not develop a comprehensive person-centered care plan for 1 sampled resident (R35) of 5 reviewed for unnecessary medications. Surveyor reviewed R35's comprehensive care plan. There is no care plan indicating the use of Melatonin for insomnia. The facility does not have a sleep assessment or sleep tracking for R35's Melatonin use. Evidenced by: The facility policy, entitled Comprehensive Care Plan, dated 9/23/22, states, in part: . POLICY: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Definitions: .Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives . Policy Explanation and Compliance Guidelines: . 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . f. Resident specific interventions that reflect the resident's needs and preferences . R35 admitted to the facility on [DATE], and has diagnoses that include weakness, obstructive sleep apnea (intermittent airflow blockage during sleep), and depression. R35's Minimum Data Set (MDS) Quarterly Assessment, dated 5/10/24, shows R35 has a Brief Interview of Mental Status (BIMS) score of 14, indicating R35 is cognitively intact. R35's Physician's Orders, dated 6/4/24 and 5/14/24, states, in part: . Melatonin Oral Tablet 3 MG (milligrams) (Melatonin) Give 2 tablets by mouth one time a day for Sleep . Order Status: Active Order Date: 3/28/24 Start Date: 3/28/24 . R35's Care Plan, dated 2/11/24, states, in part: . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: Sleep cycle issues as evidenced by poor sleep r/t (related to) depression. Date Initiated: 2/11/24. Revision on: 2/11/24. Goal: Resident will exhibit fewer signs of adequate sleep by review date. Date Initiated: 2/11/24. Target Date: 11/3/24. Interventions: Administer medications as ordered. Date Initiated: 2/11/24 . Surveyor reviewed R35's electronic health record and there is no documented sleep assessment from February 2024. Surveyor reviewed R35's Medication Administration Record (MAR) from May 2024 through July 2024 and there is no sleep tracking or effectiveness of Melatonin documented. On 8/8/24 at 1:15 PM, Surveyor interviewed VPS F (Vice President of Success). VPS F informed Surveyor the facility does not have a sleep assessment for R35. On 8/8/24 at 3:05 PM, Surveyor interviewed DON B (Director of Nursing) and asked if DON B would expect a sleep assessment for a resident on Melatonin for sleep. DON B indicated probably so. Surveyor asked DON B if a resident receiving Melatonin for sleep, would you expect sleep monitoring. DON B indicated yes; you would want to see if the Melatonin was effective.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility failed to meet professional standards of quality for 1 of 1 Residents (R40) reviewed for weights out of a total sample of 16. R40 had an order for daily weights for seven (7) days. Weights were not completed 3 out of 7 days. Evidenced by: The facility policy, entitled Weight Monitoring, dated 12/21/22, states, in part: .The interdisciplinary team will strive to prevent, monitor, and intervene for undesirable weight change for our residents.routine weights will be measured montly thereafter, unless ordered more frequently by the physician. Weights will be recorded in the individual's electronic health record. The nursing staff will notify the individual or responsible party, physician, and RDN (Registered Dietician Nutritionist) or designee of any individual with an unintended significant weight change. R40 was admitted to the facility on [DATE] with diagnoses that includes in part, essential hypertension (high blood pressure). R40's Minimum Data Set (MDS) dated [DATE], shows that R40 has a Brief Interview of Mental Status (BIMS) score of 12, indicating that R40's cognition is moderately impaired. R40's physician orders, dated 7/24/24, state; *Daily weights for next 7 days R40's Medication Administration Record (MAR) states, in part: daily weights for next 7 days, notify MD if > (greater than) 3# (pounds) in 1 day or 5# in 1 week . start 7/25/24. R40's Weights and Vitals Summary shows: *7/26/24 268 Lbs (pounds) *7/27/24 267 Lbs *7/30/24 266.8 Lbs *7/31/24 265.6 Lbs Important to note: There is no documentation of weight for 7/25/24, 7/28/24, or 7/29/24 though the MAR has signatures for the 7 dates of 7/25/24 through 7/31/24. On 8/7/24 at 4:33 PM, Surveyor interviewed RN C (Registered Nurse) and asked where weights are documented. RN C stated on the MAR or under vitals in PCC (Point Click Care--facility's electronic health record system). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 8:06 AM, Surveyor interviewed DON B and asked where weights are documented. DON B stated in PCC, as a rule; the CNAs (certified nursing assistants) write the weight on a weight sheet and the nurses document in PCC. Surveyor asked when the nurse is to document the weight in PCC. DON B stated same day. Surveyor asked if daily weights should be documented in PCC every day. DON B stated yes. Surveyor asked if staff would be aware of need to update the physician regarding change in weight if the weight was not documented in PCC. DON B stated no. Surveyor showed DON B that weights had not been documented in PCC for 3 of the 7 ordered dates. Surveyor asked DON B if facility would expect that all weights be documented in PCC to ensure that nurses would know when to update the physician. DON B stated yes. DON B asked if the facility expected that weights be documented in PCC if staff have signed for them on the MAR. DON B stated yes. The facility did not ensure that physician orders were followed for R40's daily weights.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview, and record review, the facility did not ensure that residents (R) receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, or per resident's choice for 2 of 5 residents (R35 & R11) reviewed for non-pressure wounds and 1 of 5 residents (R15) reviewed for change in condition out of a total sample of 16 Residents. R35 has blanks on his Treatment Administration Record (TAR) indicating R35's wound care had not been completed. R35 sees the wound doctor weekly. On 5/2/24 the wound doctor had ordered a treatment to R35's left shin and the order did not get transcribed onto the TAR or completed. R11 had blanks on his TAR indicating R11's wound care was not completed on those days. R15 sustained a fall. R15 was moved off the floor, after a fall, without a thorough assessment by an RN (Registered Nurse) and was later found to have a fracture. Evidenced by: The facility's policy, entitled Pressure Injuries and Non pressure Injuries, dated 7/20/22, states, in part: . Policy: . For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity . Policy Explanation and Compliance Guidelines: .2. Weekly: .iii. Initiate treatment per order . The facility policy, entitled Non-Controlled Medication Orders, dated 1/23, states, in part: .Policy: Medications are administered only upon the receipt of a clear, complete and signed order by a person lawfully authorized to prescribe . Documentation of the Medication Order: . 2. Each medication order is documented in the resident's medical record . a. New orders . -Order is recorded on the MAR (Medication Administration Record)/TAR (Treatment Administration Record) . d. Orders faxed from the prescriber's office. -The nurse on duty at the time the faxed order is received notes the order and enters it into the medical record . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Order is recorded on the MAR/TAR . Example 1: R35 admitted to the facility on [DATE], and has diagnoses that include Encounter for orthopedic aftercare following surgical amputation, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (a long-term condition in which the body has trouble controlling blood sugar and using it for energy. Polyneuropathy is a complication of type 2 diabetes mellitus that occurs when the body's peripheral nerves malfunction). R35's Minimum Data Set (MDS) Quarterly Assessment, dated 5/10/24, shows R35 has a Brief Interview of Mental Status (BIMS) score of 14, indicating R35 is cognitively intact. R35's Specialty Physician (wound physician) Initial Wound Evaluation and Management Summary, dated 5/2/24, includes: Non-Pressure Wound of the Left Shin . Dressing Treatment Plan: Primary Dressing: Leptospermum (flower from the manuka plant) Honey apply once daily for 30 days. Secondary Dressing: Gauze island with border once daily for 30 days. R35's May 2024 TAR includes the following: -Wound Care to blister on LLE (left lower extremity): Paint intact blister on LLE with betadine daily. One time a day for wound care- blister Start Date: 5/7/24 . D/C (discontinue) Date: 5/17/24 . Dates 5/8/24, 5/12/24, 5/13/24, 5/14/24 and 5/16/24 are left blank/not signed out on the TAR for this order. -Wound Care to LLE: Cleanse open wounds to LLE with soap and water, pat dry, then apply Foam dressing with border. Change every 3 days, and PRN (as needed) until healed one time a day every 3 days for wound care. Start Date: 5/7/24 . D/C Date: 5/17/24 . Dates: 5/13/24 and 5/16/24 are left blank/not signed out on the TAR for this order. Note: There is no order on TAR for the ordered Primary Dressing: Leptospermum honey apply once daily for 30 days. Secondary Dressing: Gauze island with border once daily for 30 days to Left Shin as ordered on 5/2/24. R35's July TAR includes the following: Apply skin prep to areas on left toe once daily one time a day for skin. (Start Date: 6/14/24.) Dates 7/12/24 and 7/17/24 are left blank/not signed out on the TAR for this order. R35's Care Plan, dated 2/2/24, states, in part: .Focus: At risk for alteration in skin integrity related to: recent surgery, decreased mobility, diabetes .Interventions: . Treatment as ordered per MD (medical doctor). See wound MD as needed. Date Initiated: 5/2/24. No documentation was provided to show that R35's wound care treatments were done on the dates that were left blank/not signed out on the TAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 1:22 PM, Surveyor interviewed IP D (Infection Preventionist/Wound Nurse). Surveyor asked IP D what the process is when the wound doctor comes to the facility and writes new orders for wound care. IP D indicated she does rounds with him. The wound doctor's notes go under the miscellaneous tab in PCC (Point Click Care). The next day IP D looks at the orders and if there are changes IP D updates the TAR. IP D indicated she took over as wound care nurse in June and she is responsible for entering orders into the TAR. On 8/8/24 at 3:10 PM, Surveyor interviewed DON B (Director of Nursing) and asked what the process is when the wound doctor comes to the facility and writes new orders for wound care and who is responsible. DON B indicated IP D is responsible for entering the orders into the TAR. DON B indicated at the end of the day when the wound doctor is at facility, IP D is responsible for entering the new orders into the TARS. DON B indicated the new orders are expected to be started the next day. Surveyor asked DON B, looking at the wound doctor's orders dated 5/2/24, were these orders entered into the TAR and completed. DON B looked through the TAR in the computer and indicated no, the orders are not in the TAR and were not completed. Surveyor asked if the orders should have been entered into the TAR on 5/2/24 and DON B indicated yes. DON B indicated he would have expected the orders to be started the next day on 5/3/24. Surveyor asked DON B if there are blanks on the TAR what does that indicate. DON B indicated if not documented it is not done. Surveyor showed DON B the blanks on R35's TAR (5/8, 5/12, 5/13, 5/14, 5/16) and asked if these treatments were completed and DON B indicated if not documented it is not done. R35's wound treatments were not completed per MD orders. 36192 Example 2: R11 was admitted on [DATE] with diagnoses of orthopedic aftercare following surgical amputation, acute osteomyelitis (right hand,) and peripheral vascular disease. July 2024 Treatment of Administration (TAR) record indicates the following: Arterial wound left 2nd finger, full thickness, apply iodosorb gel and cover with bordered gauze once daily for 30 days (start 7/13/24, D/C (discontinue) date 7/19/24) is blank/not signed out on the TAR for night shift on 7/19/24. Arterial wound left 2nd finger, full thickness, apply iodosorb gel and cover with bordered gauze once daily for 30 days (start 7/20/24, D/C (discontinue) date 7/30/24) Wound care: Monitor left hand tip of thumb and thumb nail is necrotic. Apply betadine once daily, leave open to air one time a day for wound care (start date 7/14/24) is blank/not signed out on the TAR for PM shift on 7/17/24. Wound care: Right hand, daily dressing changes. Cleanse with normal saline, pat dry, apply xeroform over the sutures, and wrap with a rolled gauze followed by ace wrap one time a day for wound care (start date: 7/3/24) is blank/not signed out on AM shift on 7/17/24 and 7/24/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No documentation was provided to show that R11's wound care treatments were done on the dates that were blank/not signed out on the TAR. On 8/8/24 at 3:18 PM, Surveyor interviewed DON B (Director of Nursing) regarding R11's treatments. When informed that R11 has blanks/dates not signed out for treatments on his TAR, DON B stated, If it's not documented it's not done. 39849 Example 3 The facility policy, titled Fall Prevention and Management Guidelines, with a reviewed/revised date of 7/18/24, indicates, in part: .Policy Explanation and Compliance Guidelines: .7. When any resident experiences a fall, the facility will: a. Complete a post-fall assessment and review: 1) Physical assessment with vital signs . 4) Resident and/or witness statements regarding fall .e. Document all assessments and actions . R15 was admitted to the facility on [DATE], diagnoses include, in part: Hemiplegia (one sided paralysis) and Hemiparesis (one sided partial weakness) following cerebral infarction (stroke) affecting right dominant side, difficulty in walking, age-related osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases and can increase the risk of fractures), and Parkinsonism. R15's Minimum Data Set (MDS) with a target date of 5/21/24 indicates a Brief Interview for Mental Status (BIMS) summary score of 12, indicating R15's cognition is moderately impaired. R15's Nursing Progress Notes indicate the following, in part: --5/9/24 12:47 PM - Clinical Follow-up: Note Text: The current status is sitting in w/c (wheelchair) eating lunch. monitor per policy. --5/9/24 1:44 PM - Communication with Physician: Situation: recent fall at 11AM - c/o (complains of) right hip pain. Background: reaching for snack and fell out of w/c. Assessment (RN)/Appearance(LPN): right hip swollen. Assessment: requesting to go to ER (emergency room). Recommendations: Response: Order received to send to ER. --5/9/24 2:00 PM - General Note: Note Text: requesting to be sent to ER d/t (due to) c/o right hip/leg pain . EMS (Emergency Medical Services) arrived at 1:50 PM . On 8/8/24 Surveyor was unable to locate a Fall Report/Investigation for R15 in the medical record and requested this from the facility. On 8/8/24 the facility provided the following, in part, and indicated it was from their risk management documentation: The document indicates Risk Management at the top of the document with an effective date of 5/9/24. There is no complete patient name on the document, only a first name in the note text and there is no documentation of who the author is. (continued on next page)

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Monroe Health Services	516 26th Ave Monroe, WI 53566

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note Text indicates: R15's family brought in cupcakes for his birthday. R15 was eating one and dropped it on the floor. Patient reached for cupcake on the floor and fell . Resident States, I was reaching for a cupcake that my brother brought me for my birthday. Patient showed no signs or symptoms of pain or discomfort and was transferred back to wheel chair. Education on call light was given immediately. Patient stated I know I should of used by call light to ask for help Patient transferred back to bed with 2 person full body lift where he started to complain of pain in hip. Orders to send to ER for eval (evaluation). R15's Post Fall Assessment, with an effective date and time of 5/9/24 at 12:38 PM, includes, in part: Date and Time of Fall 5/9/24 00:00 (Of note, this time differs from the 5/9/24 1:44 PM nursing progress note that indicated the fall occurred at 11:00 AM) .Current vitals: Blood Pressure 175/79, Pulse 61, Respiration 20 . The document is electronically signed by RN E (Registered Nurse) It is important to note, this document does not include a full physical assessment such as range of motion, shortening of extremity concerns, internal or external rotation concerns, level of pain in general or pain with palpation, obvious signs of injury, etc. R15's Post Event Observation, with an effective date and time of 5/9/24 at 12:47 PM, includes, in part: A. Focus 1. Reason. 2. Fall . A. Focus 6. Most Recent Pain Level: Pain Level: 0 Date: 5/9/24 6:39 AM (Of note, this time is prior to the time the fall was documented as occurring.) 6a. Pain location: right leg. 7. Current status: sitting in w/c eating lunch. 8. Action taken: monitor per policy. This document is electronically signed by RN E. R15's Hospital Discharge Summary for admitted s 5/9/24 to 5/15/24 indicate, in part: Clinical Resume: R15 . was admitted with Right Intertrochanteric Fracture due to a combination of osteoporosis and trauma, as trauma alone would not have caused the fracture . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 9:57 AM, Surveyor interviewed RN E via telephone regarding R15's fall on 5/9/24. During the interview RN E indicated that if the facility had not provided the risk management documentation to us that some of her documentation would be in there. RN E indicated R15's brother had brought him cupcakes and R15 reached over to get one, the container was closed, and he ended up tipping out of his chair when he went to get one. RN E indicated she was up by the nurse's station assisting another resident when someone alerted there was a resident on the floor. RN E indicated that she saw NHA A (Nursing Home Administrator), who she states is also an LPN (Licensed Practical Nurse), go down and that as soon as she was done assisting the resident she was with she went down to the room. RN E indicated that NHA A cannot do an assessment because he is an LPN. RN E indicated by the time she got to the room R15 had already been picked up off the floor so she did not know what position he was in and couldn't assess him on the floor as he had already been moved. RN E indicated R15 had been moved into a wheelchair and that a CNA (Certified Nursing Assistant) and NHA A were in the room when she arrived. RN E could not recall who the CNA was. RN E indicated she brought the vitals machine and completed neuro checks per protocol but did not complete a full assessment. RN E indicated that she asked R15 if he was having pain and he said a little bit in his right leg. RN E indicated R15 said he just wanted to go to lunch and to get him to lunch and refused further assessment. RN E indicated she told R15 she needed to assess him but he didn't want to and kept saying just get me to lunch. RN E indicated after lunch he started to complain of more pain in the right leg and so she messaged the provider and got an order to send him out for evaluation to the ER. Surveyor asked RN E if she was able to assess R15's leg after lunch. RN E indicated she was not able to assess his leg after lunch either because he was sitting in the w/c and she asked him and he refused for her to assess the hip and so she asked him if he wanted an x-ray and he said yes. Surveyor asked RN E if R15 stayed in his w/c until EMS (Emergency Medical Services) arrived. RN E indicated they put him in bed as EMS was getting there. Surveyor asked RN E if she recalled how they got R15 into bed. RN E indicated she did not remember and that she may not have been there because she may have been getting paperwork ready. Surveyor asked RN E if she would have given approval for staff to move R15 from the w/c to the bed. RN E indicated she did not recall if she did or not. Surveyor asked RN E with the amount of pain R15 was in if he should have been moved or left in the w/c for EMS to assist. RN E indicated, they should have left him in the w/c where he was. It is important to note that R15 was moved, after a fall, on two separate occasions without evidence of a complete RN assessment. On 8/8/24 at 10:36 AM, Surveyor interviewed R15 regarding the fall on 5/9/24. R15 was not able to provide details from the fall or post fall other than that he recalled he was reaching for a cupcake and fell out of his w/c and broke his hip. R15 indicated he could not recall staff assisting him after the fall or recall being moved or refusing to allow staff to physically assess him. On 8/8/24 at 3:51 PM, Surveyor interviewed DON B (Director of Nursing) and asked what the expectation of nursing staff is immediately after a resident has a fall. DON B indicated: Risk management documentation and follow-up; An assessment, to included: vital signs, a head to toe assessment, and depending on the incident, range of motion; Contact physician, DON, family, MCO (Managed Care Organization). Surveyor asked DON B if any staff member should move a resident prior to a RN assessment. DON B indicated, no. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked DON B what he knew of R15's fall on 5/9/24. DON B indicated it was reported to him that it was R15's birthday and he dropped a cupcake on his floor and was reaching for it, slid out of his w/c, and landed on his bottom. They put R15 into his bed, he had no complaints of pain or injury. DON B indicated he could not give an exact time but he thought about 2 hours later he began complaining of right leg pain. DON B indicated he went in and assessed R15's leg and he had pain in the pelvis area and 911 was called and he was transported. Surveyor asked DON B if as far as he was aware R15 went directly to his bed after the fall. DON B indicated he was aware of RN E doing an assessment and then her and the CNA laying R15 back in bed. Surveyor asked DON B if he documented his assessment or if he had documentation of RN E's assessment. DON B indicated he was not sure and began looking in the facility EHR (Electronic Medical Record). DON B indicated he was unable to locate documentation of the assessments and that they should be documented in the medical record. On 8/8/24 at 4:18 PM Surveyor interviewed NHA A and asked what he knew of R15's fall on 5/9/24. NHA A indicated that R15 was reaching for a cupcake because it was his birthday and he fell reaching for it. NHA A indicated he assisted with the post fall risk management information. Surveyor asked NHA A if he went to R15's room when he fell . NHA A indicated he thought he went after the fact, just to see where it happened. Surveyor asked NHA A if he cared for R15 at anytime between the fall and when he was moved. NHA A indicated, not that he recalled. Surveyor asked NHA A if he recalled what nurse went to take care of R15 after the fall. NHA A indicated, I believe it was RN E, the documentation I saw was her. Surveyor asked NHA A if he knew who moved R15 after the fall. NHA A indicated he believed it was a CNA and RN E. Surveyor asked NHA A if he was able to find documentation of an RN assessment prior to R15 being moved. NHA A indicated he could not see one and there should have been one completed. Surveyor asked NHA A if he, at any time, moved R15. NHA A indicated, no. There is no evidence documented of a complete physical assessment by a Registered Nurse prior to R15 being moved from the floor to the w/c after a fall.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview, and record review, the facility did not implement professional standards of practice to promote healing or prevent pressure injury (PI) development for 1 of 2 residents reviewed for PIs out of a sample of 16 residents (R147). On 5/23/24 the wound doctor ordered Leptospermum honey (honey from the flowers of the Manuka bush) apply once daily for 23 days. Secondary Dressing: Gauze island with border apply once daily for 23 days for R147. This order did not get entered/transcribed onto R147's Treatment Administration Record (TAR) and was not completed as ordered on multiple days. Evidenced by: The facility's policy, entitled Pressure Injuries and Non pressure Injuries, dated 7/20/22, states, in part: . Policy: . For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity . Policy Explanation and Compliance Guidelines: . 2. Weekly: . iii. Initiate treatment per order . The facility policy, entitled Non-Controlled Medication Orders, dated 1/23, states, in part: .Policy: Medications are administered only upon the receipt of a clear, complete and signed order by a person lawfully authorized to prescribe .Documentation of the Medication Order: .2. Each medication order is documented in the resident's medical record . a. New orders . -Order is recorded on the MAR (Medication Administration Record)/TAR (Treatment Administration Record) . d. Orders faxed from the prescriber's office. -The nurse on duty at the time the faxed order is received notes the order and enters it into the medical record . -Order is recorded on the MAR/TAR . R147 admitted to the facility on [DATE], and has diagnoses of osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), paraplegia (a chronic condition that causes a loss of muscle function in the lower half of the body, including the legs, feet, toes, and sometimes abdomen), and weakness. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R147's Specialty Physician Wound Evaluation and Management Summary, dated 5/23/24, states, in part: . Stage 3 Pressure Wound of the Left Calf . Dressing Treatment Plan: Primary Dressing: Leptospermum honey apply once daily for 23 days. Secondary Dressing: Gauze island with border apply once daily for 23 days. (until 6/14/24) . R147's Care Plan, dated 4/16/24, states, in part: . Focus: The resident has healing pressure ulcer Right and Left Calf r/t (related to) paraplegia .Interventions: .Administer treatments as ordered and monitor for effectiveness. Date Initiated: 4/16/24 .Weekly treatment documentation to include measurement .Date Initiated: 4/16/24 . R147's May TAR includes: Wound Care to left calf. Cleanse area and pat dry. Apply medihoney and cover with bordered gauze daily. One time a day. Start Date: 4/19/24 . D/C (discontinue) Date: 5/21/24 . Note: TAR shows no treatment to left calf from 5/21/24 through 5/31/24. R147's June TAR includes: Left Calf- Cleanse wound and apply medihoney and cover with bordered gauze once daily one time a day. Start Date: 6/7/24. D/C Date: 6/28/24. Note: TAR shows no treatment to the left calf from 6/1/24 - 6/6/24. (Of note: R147's wound was present upon admit and did not worsen during the time frames that the wound care was not completed.) On 8/8/24 at 3:35 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor reviewed the wound doctor orders dated 5/23/24 with DON B and asked if these orders were entered onto R147's TAR and completed as ordered. DON B indicated the orders were not on R147's TAR from 5/21/24- 6/6/24. Surveyor asked DON B if these orders should be on R147's May TAR and DON B indicated yes, he would expect them to be on the TAR and completed. Surveyor asked DON B if these orders had been completed and DON B indicated if it was not documented it was not done. Treatment to R147's pressure injury was not completed per physician orders on multiple days.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49434 Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 2 errors out of 34 opportunities that affected 2 out of 2 residents (R12 and R35) included in the medication pass task, which resulted in an error rate of 5.88%. RN C (Registered Nurse) did not assess the resident's heart rate or blood pressure prior to administration according to physician orders. LPN G (Licensed Practical Nurse) administered a medication with breakfast instead of one hour before breakfast according to physician orders. This is evidenced by: Facility policy entitled, Medication Administration, dated 01/2023, states in part: Policy: Medications are administered as prescribed in accordance with manufacturers' specifications . Procedures: Medication Preparation: . 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record .Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber . 2. Obtain and record any vital signs as necessary prior to medication administration. 3. Medication administration timing parameters include the following: a. Medications to be given on an empty stomach or before meals are to be scheduled for administration 30 minutes to 2 hours prior to meals . 14. Medication are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes . Example 1: R12's Physician Orders state, in part: Lisinopril Oral Tablet 10 MG (milligram) (Lisinopril) Give 1 tablet by mouth one time a day related to HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE (I11.9) hold if SBP (systolic blood pressure) <100 (less than 100) or DBP (diastolic blood pressure) <60 or HR (heart rate) <60 and notify MD (medical doctor). (Start date: 7/20/2024) On 8/7/24 at 8:00 AM, Surveyor observed RN C prepare 22 medications for R12, including one Lisinopril 10 MG tablet. Surveyor observed this medication be added to the small, plastic medication cup and administered to the resident. After reviewing R12's physician orders, it was found that R12's Lisinopril order included parameters to hold the medication for a blood pressure under 100 systolic and 60 diastolic, as well as orders to hold for a heart rate less than 60. Of note: Surveyor did not observe R12 assess the resident's vital signs prior to medication administration. The last vital signs recorded for R12 were taken on 8/5/24. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 11:38 AM, Surveyor interviewed RN C. Surveyor asked RN C how often R12's vital signs should be taken. RN C states that it used to be daily, but about a month ago that was discontinued, and RN C believes that now it is once a week. Surveyor asked RN C if she took R12's vital signs this morning. RN C states no, she did not. Surveyor asked RN C to review R12's Lisinopril order and asked what the order indicates. RN C states that there are hold orders for vital sign parameters. Surveyor asked RN C, knowing this, should R12's vital signs been taken this morning prior to the Lisinopril being administered. RN C stated, yes, absolutely. Example 2: R35's Physician Orders state, in part: Omeprazole Oral Tablet Delayed Release 20 MG (Omeprazole) Give 1 tablet by mouth one time a day for GERD (Gastroesophageal Reflux Disease) Give one hour before breakfast. On 8/7/24 at 8:14 AM, Surveyor observed LPN G prepare 12 medications for R35, including one Omeprazole 20 MG tablet. Surveyor observed this medication be added to the small, plastic medication cup and administered to the resident. While in R35's room, Surveyor observed the resident sitting upright in a wheelchair in front of a bedside table with his breakfast tray on top and uncovered. After reviewing R35's physician orders, it was found that R35's Omeprazole order included instructions that the medication be administered 1 hour before breakfast. On 8/7/24 at 11:47 AM, Surveyor interviewed LPN G. Surveyor asked LPN G if I what R35's Omeprazole order states. LPN G states that the Omeprazole should be administered one hour before breakfast. Surveyor asked LPN G if R35 had his breakfast tray when the medications were administered. LPN G states, yes. Surveyor asked LPN I if R35 was administered his omeprazole one hour before he ate breakfast. LPN G states, no. Surveyor asked LPN G if R35's Omeprazole should have been administered one hour before he ate breakfast. LPN G states, yes. On 8/7/24 at 12:55 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if it is his expectation that medications be administered as ordered. DON B states, yes. Surveyor asked DON B if he would expect vital signs to be taken if medication have a hold order with vital sign parameters. DON B states, yes. Surveyor asked DON B if he would expect a medication with orders to be given one hour before breakfast to be administered as ordered. DON B states, yes. Surveyor asked DON B if he would consider administering the lisinopril without taking vital signs and administering omeprazole with breakfast instead of one hour before medication errors. DON B states, yes and that he has already started the facility medication error process including notifying the physician. Surveyor asked DON B if vital signs should have been taking prior to administering lisinopril. DON B states, yes. Surveyor asked DON B if omeprazole should have been given an hour before breakfast. DON B states, yes. R12 and R35's medications were not administered per physician orders.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review the facility did not maintain medical records on each resident that are complete; accurately documented; readily accessible, and systematically organized for 1 of 16 sampled residents (R39) reviewed for fall risk. R39's medical record contains inaccurate fall risk assessments following five (5) falls within the facility over the span of three (3) months. This is evidenced by: R39 was admitted to the facility on [DATE] with diagnosis that include in part: encephalopathy (brain disease or dysfunction that causes and altered mental state), vascular dementia, and polyneuropathy (peripheral nerve damage causing weakness, numbness, and pain). R39's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 7/25/24, indicates a Brief Interview of Mental Status (BIMS) of 3 out of 15, indicating R39 is severely cognitively impaired. Section GG indicates the resident utilizes a wheelchair for mobility. GG0170: Mobility indicates R39 requires partial/moderate assistance to move from sitting to standing. It also indicates R39 requires substantial/maximal assistance for chair/bed-to-chair transfers, toilet transfers, and tub/shower transfers. GG0170 also indicates that the facility could not attempt to have R39 walk 10 feet due to a medical condition or safety concerns. R39's Comprehensive Care Plan indicates, in part: Focus: R39 is a high risk for falls due to a history of falls, medications, weakness, decreased mobility, and a recent hospitalization . Date initiated: 4/19/24. Interventions include: room move if family is ok, lay down after meals, toilet after meals, bed in low position, dycem in w/c (wheelchair). Focus: R39 will use w/c while eating and in activities. Date initiated: 4/19/24. Interventions include: encourage to transfer and change positions slowly, FALL RISK (FYI), Have commonly used articles within easy reach, reinforce need to call for assistance, reinforce w/c safety as needed such as locking brakes, report development of pain, bruises, change in mental status, ADL (activities of daily living) function, appetite or neurological status post fall, sign to ask for help when getting up by recliner. R39's falls include: Post Fall assessment dated [DATE] at 12:00 PM. Assessment indicates that a fall occurred on 5/9/24 at 11:40 AM. Progress notes indicate that the fall was unwitnessed, and resident was found on the floor. The Fall Risk Assessment, which is included with the Post Fall Assessment, indicates a score of 22 indicating high fall risk. Post Fall assessment dated [DATE] at 11:42 PM. Assessment indicates a fall occurred on 5/9/24 at 7:00 PM. Progress notes indicate a second unwitnessed fall that was believed to have occurred when R39 attempt to use the bathroom by himself. The Fall Risk Assessment, which is included with the Post Fall Assessment, indicates a score of 10 indicating low fall risk. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post Fall assessment dated [DATE] at 2:40 AM. Assessment indicates a fall occurred on 5/10/24 at 7:10 PM. Progress note indicates that this is the third unwitnessed fall. The Fall Risk Assessment, which is included with the Post Fall Assessment, indicates a score of 15 indicating moderate fall risk. Post Fall assessment dated [DATE] at 2:11 PM. Assessment indicates a fall occurred on 6/5/24 at 1:00 PM. Assessment indicates that this is the fourth unwitnessed fall. The Fall Risk Assessment, which is included with the Post Fall Assessment, indicates a score of 9 indicating low fall risk. Of note: This Fall Risk Assessment indicates that R39 had no falls in the past 30 days and 1-2 falls in the past 90 days, when they actually had 3 falls. Additionally, it does not indicate the medications that R39 is has physician orders for that increase fall risk including a diuretic, a laxative, a psychotropic medication, and an antidepressant that are indicated on some prior assessments. Post Fall assessment dated [DATE] at 6:01 PM. Assessment indicates a fall occurred on 8/1/24 at 6:00 PM. Assessment indicates that this is the fifth unwitnessed fall. The Fall Risk Assessment, which is included with the Post Fall Assessment, indicates a score of 10 indicating low fall risk. Of note: This Fall Risk Assessment indicates that R39 had 1-2 falls in the past 90 days and 1-2 falls in the past 180 days, when the resident actually had 4 falls in the past 90 days. Additionally, it does not indicate the medications that R39 is has physician orders for that increase fall risk including a diuretic, a laxative, a psychotropic medication, and an antidepressant that are indicated on some prior assessments. On 8/8/24 at 8:44 AM, Surveyor interviewed LPN H (Licensed Practical Nurse). Surveyor asked LPN H what the process is after a resident falls. LPN H states, we get vitals, do an assessment, make sure nothing is hurting, utilize a hoyer lift to get them back up. Once the resident is off the floor, we ask them what happened, ask witnesses what happened, do notifications for the physician and HCPOA (Healthcare Power of Attorney), and then we do the fall risk assessment and continue neurological checks. Surveyor asked LPN H if recent falls increase someone's fall risk. LPN H states of course they do, along with a resident BIMS and medications. Surveyor asked LPN H if R39 is a high fall risk. LPN H states yes, due to his BIMS score, he has a sore ankle, and his recent intervention of the sign next to his chair is hit or miss for effectiveness. On 8/8/24 at 8:55 AM, Surveyor interviewed RN C (Registered Nurse). Surveyor asked RN C what the process is after a resident falls. RN C states, after I am notified, I go right to the room, assess for injury, ask what happened and if the resident hit their head. After that, RN C would start neurologic checks, assess vital signs, assist the resident off the floor, notify the physician and HCPOA, assess for skin issues, notify DON (Director of Nursing) and NHA (Nursing Home Administrator), and do a post fall and risk assessment. Surveyor asked RN C if previous falls increase resident fall risk. RN C states, absolutely. Surveyor asked RN C if R39 was a high fall risk. RN C states, yes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525292	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Health Services	516 26th Ave Monroe, WI 53566

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 3:52 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what his expectations were for staff after a resident falls. DON B states staff are to do an incident report, risk management, document the fall, notify family, the physician, and himself. Surveyor asked DON B what the assessment includes. DON B states vital signs, head-to-toe assessment, and range of motion. Surveyor asked if this would also include a fall risk assessment. DON B states, yes, I would expect them to be filled out. Surveyor discussed with DON B that 3 out of 5 of R39's post fall assessments, R39 was determined to be a low fall risk. Surveyor then asked DON B if he would consider these to be accurate fall risk assessments. DON B states, no. Surveyor asked DON B if these assessments should be accurate. DON B states, yes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on interview and record review, the facility did not ensure they followed their antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 1 of 1 (R2) supplemental residents reviewed for antibiotic stewardship. R2 was given an antibiotic before all test results were returned and continued to take it after results despite lack of appropriate indications for its use. This is evidenced by: The facility policy titled, Antibiotic Stewardship Program, with a reviewed date of 1/24/24, indicates, in part: Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Policy Explanation and Compliance Guidelines: .4. The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility uses the updated McGeer criteria to define infections .b. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made . On 8/7/24 and 8/8/24 Surveyor reviewed the facility's Infection Control Line List documentation as part of the facility's Infection Control Program review. R2 was admitted to the facility on [DATE] and the July 2024 Infection Control Line List indicated the following for R2: Type of Infection: UTI (Urinary Tract Infection) .Signs and Symptoms: dysuria, urgency and abdominal pain. Criteria Met: Yes. Date of Onset: 7/12/24. Results/Organism: >=100,000 mixed flora .Treatment: Cefuroxime . Notes: UTI treated with cefuroxime x 7 days. An electronic encounter (a communication with the provider via electronic messaging), electronically signed by the physician on 7/12/24 at 2:31 PM, indicates the following: Looks like a UTI. Until culture is back, let's treat with cefuroxime 250 mg bid (twice a day) x 7 days with 0 refills. A Urine Culture Order with a collected date of 7/12/24 and a last resulted date of 7/13/24 indicates the following: Result Note: Urine Culture >= 100,000 CFU/ml (colony forming units/ml). No further workup performed. Mixed multiple morphologies present including potential uropathogens; suggest recollection if clinically indicated. R2's Medication Administration Record (MAR) indicates the following: Cefuroxime Axetil .Give 250mg (milligrams) by mouth two times a day for UTI until 7/19/24 .Start Date: 7/13/24. This medication is marked as administered twice daily from 7/13/24 through 7/18/24 and once in the AM of 7/19/24. (continued on next page)

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	525292	A. Building B. Wing	08/08/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 8:59 AM, Surveyor interviewed ADON/IP D (Assistant Director of Nursing/Infection Preventionist) and DON B (Director of Nursing). Surveyor reviewed the above information regarding R2 and asked if it met criteria for treating with an antibiotic. ADON/IP indicated that she just went by the >100,000 for treatment. Surveyor reviewed the note on the urine culture indicating: No further workup performed. Mixed multiple morphologies present including potential uropathogens; suggest recollection if clinically indicated, with ADON/IP D and DON B. DON B indicated in the interview that his expectation with this culture result would have been for the physician to be contacted to discuss the results and to collect a new urine sample if needed. R2 was started on an antibiotic for suspected UTI prior to urine culture results being finalized. R2 was kept on an antibiotic after urine culture results indicated mixed flora (no specific bacteria was isolated) and that no further work-up would be performed. Therefore, a sensitivity, which would determine the effectiveness of the antibiotic against the microorganisms (germs) such as bacteria, was not performed. A recollection was not obtained or discussed with the Physician.